MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (173)

CERTIFICATE OF DEATH

10999

Reg. Dist. No. 106

1. PLACE OF DEATH:
County Charles (Indian Head)
City or town Rural (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: (Potomac River)
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State N. C. County
City or town (If outside city or town limits, write RURAL NEAR and give town) Ward No.
Street No. (If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Fred H. Covington

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 27, 1913

8. AGE: Years 31 | Months 11 | Days 14 | If less than one day ____hrs. ____min.

9. Birthplace N. C. (Town, county, and state)

10. Usual occupation Airplot U.S.N.

11. Industry or business U.S. Navy

FATHER 12. Name Dr. J. M. Covington
FATHER 13. Birthplace Unknown

MOTHER 14. Maiden name "
MOTHER 15. Birthplace "

16. Informant Mary Reade
Address

17. Transportation (Burial, cremation, or removal. Which?) Date thereof Dec 2, 1945 (month) (day) (year)

Cemetery or crematory
Location Waterboro, N.C.

18. Funeral director Wise Funeral Home
Address 29 W. M. St. N. W.

19. 11/30 1945 Eddy Price
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11 1945, at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____19____, to ____19____, and that I last saw h____alive on ____19____.

Immediate cause of death Drowning accidental result of bailing out of
Due to crashing Plane. Plane was Testing for
Due to Crashed at Indian Head
Other conditions M.E. Body received at Stump Neck
(Include pregnancy within 3 months of death)

DURATION

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 11/11/45
Where did injury occur? Indian Head Charles Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Airfield
Means of injury Drowning Injured at work?

23. SIGNATURE F. J. G. Simon M.D.
M. D. or other
Address Indian Head, Md. Date signed 11/30/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (173)

CERTIFICATE OF DEATH

11000

Reg. Dist. No. 106

1. PLACE OF DEATH:
County: Charles
City or town: Rural Indian Head
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: (Potomac River)
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.:
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME Stephen Deckman Lt. JG. USNR

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Lorraine Eddy Deckman
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 16, 1912

8. AGE:

Years	Months	Days	If less than one day
33	5	25	hrs. min.

9. Birthplace: Lakeland, Fla.
(Town, county, and state)

10. Usual occupation: U.S. Navy

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden name: "
15. Birthplace: "

16. Informant: Navy records
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 4, 1945 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: Wise Funeral Hall
Address: 2900 M. St. N.W. Washgn.

19. 11/30/45 (Date rec'd by registrar) Oby Price Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 1, 1945, at 8P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____, 19__, to ____, 19__, and that I last saw h__ alive on ____, 19__.

Immediate cause of death:	DURATION
Drowning, accidental result of bailing out of Crashing plane	
Due to Plane crashed at Indian Head and Body recovered near Chicamuxen	
Due to (Ordnance Eng. Laboratory)	
Other conditions: Stump Neck, Indian Head, Md.	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 11-11-45
Where did injury occur? Indian Head (City or town) Chas (County) Md (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Plane Crash Injured at work?

23. SIGNATURE: Frank Lyon M.D.
M. D. or other
Address: Indian Head, Md. Date signed 11/30/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11001

★ Reg. Dist. No. 106

1. PLACE OF DEATH:
County: Charles
City or town: Indian Head, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Penna. County:
City or town: Abbington
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Eggleton, Joseph Peter

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: None

6.(c) If alive, give age: 19 years

7. Birth date of deceased (mo., day, yr.): 4-6-26

8. AGE: Years	Months	Days	If less than one day
19	7	5	hrs. min.

9. Birthplace: Abbington, Penna. (Town, county, and state)

10. Usual occupation: Cox. U.S.N.R. V-6

11. Industry or business

FATHER — 12. Name: UNKNOWN
13. Birthplace

MOTHER — 14. Maiden name: Helen Eggleton
15. Birthplace: UNKNOWN

16. Informant
Address

17. Burial, cremation, or removal (which?): Removal-NNMC
Date thereof: (month) (day) (year)

Cemetery or crematory: UNKNOWN
Location

18. Funeral director: U.S. Navy
Address: Indian Head, Md.

19. 11/4 1945 (Date rec'd by registrar) Odey Prue Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11-11-45 1945 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945, to 1945 and that I last saw him alive on 19

Immediate cause of death	DURATION
Asphyxiation	
Death by drowning	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: 11-11-45
Where did injury occur? Potomac River, (City or town) Indian Head (County) Md. (State)
Injured at home, farm, industry, public place (where?): work
Means of injury: drowning Injured at work? yes

23. SIGNATURE: (s) E. Peed M. D.
M. D. or other
Address: Naval Dispensary Date signed: 11/11/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (926)

CERTIFICATE OF DEATH

11962, 05

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: Charles Co.

City or town: Waldorf

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all her life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Chas. Co, Md

City or town: Waldorf, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Martha Hagen

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Col.	Married

B.(b) Name of husband or wife: William Hagen

6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): Oct 15 - 1870

8. AGE:

Years	Months	Days	If less than one day
75	1	0	...hrs. ...min.

9. Birthplace: Charles Co. Md

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At Home

FATHER

12. Name: Dorsey Throw

13. Birthplace: Chas Co. Md.

MOTHER

14. Maiden name: Vennie Vern Blair

15. Birthplace: Chas Co. Md

16. Informant: William Hagen

Address: Waldorf Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-18-45 (month) (day) (year)

Cemetery or crematory: St Peters Cemetry

Location: Waldorf Md

18. Funeral director: Hamilt & Taylor

Address: Waldorf Md

Nov 18 19 45 — M. L. Moore, Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 16 19 45, at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 14 19 45 to ... 19 ...

and that I last saw h[illegible] alive on Nov 14 19 45

Immediate cause of death	DURATION
Chronic Myocardiate Insuf.,	
Chronic mitral regurgitation	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: John E. Powers, M. D. or other

Address: Brandywine, Md Date signed ...

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for addition of information on certificate is shown on FILM No. I 00 FEB 14 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

11003

Reg. Dist. No. 10-6

1. PLACE OF DEATH:
County CHARLES
City or town INDIAN HEAD, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2mos. 3 days
Hospital, Institution, or street address where death occurred: POTOMAC RIVER
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME HALL, Fredrick B. Commander USNR.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 10, 1910

8. AGE: Years	Months	Days	If less than one day
34	11	2	hrs. min.

9. Birthplace St. Louis, Mo. (Town, county, and state)
10. Usual occupation Naval Officer
11. Industry or business United States Navy
FATHER 12. Name Unknown
13. Birthplace Unknown
MOTHER 14. Maiden name Mrs. Corinne Steele Hall
15. Birthplace Unknown
16. Informant
Address
17. Removal (Burial, cremation, or removal. Which?) Date thereof 16 January 1946 (month) (day) (year)
Cemetery or crematory
Location
18. Funeral director WISE, George
Address 2900M St. N.W. Washington, D.C.
19. Jan. 16 1946 (Date rec'd by registrar) Odey Price Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 November 1945 at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to at 16 January 46 19
and that I last saw h alive on 19

	DURATION
Immediate cause of death Asphyxiation	
Due to Drowning	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 1945
Accident, suicide, or homicide Accident Date of 12 November
Where did injury occur? Indian Head, Maryland (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Potomac River
Means of injury Plane Crash Injured at work? Yes

23. SIGNATURE W. E. Fleischer W.E.FLEISCHER Comdr. (MC)USNR.
Address NavPowFac. Indian Head, Md. M. D. or other Date signed 1-16-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct name is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

11604

★ Reg. Dist. No. 100

1. PLACE OF DEATH

County: Charles

City or town: La Plata Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Charles

City or town: La Plata Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Dorothy Johnson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Col	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 10 - 1933

8. AGE: Years	Months	Days	If less than one day
12	7	12	..... hrs. ..... min.

9. Birthplace: La Plata Md (Town, county, and state)

10. Usual occupation: Scholar

11. Industry or business

FATHER 12. Name: Roy Johnson

13. Birthplace: La Plata Md

MOTHER 14. Maiden name: Sarah Savoy

15. Birthplace: Brittons Md

16. Informant: Roy Johnson

Address: La Plata Md

17. Burial (Burial, cremation, or removal, Which?) Date thereof 11-26-45 (month) (day) (year)

Cemetery or crematory: St. Caneline

Location: St. Caneline Md

18. Funeral director: Truitt & Bryan

Address: Hardey Md

19. 11-24 1945 Julia H. Posey

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11/22/45 19..., at ... M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 11/22/45 19... to 11/22/45 19...

and that I last saw h... alive on 11/22/14 19...

Immediate cause of death	DURATION
Due to: Labor Pneumonia	5 day
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op...

Autopsy results: Convulsions & Lung

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Edward A Dukes M.D. M. D. or other

Address: Hughesville Md Date signed 11/22/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

11005

Reg. Dist. No. 101

1. PLACE OF DEATH:

County: Charles

City or town: Ironsides

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Charles

City or town: Ironsides Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Evelyn Johnson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	C	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 10 1914

8. AGE:

Years	Months	Days	If less than one day
31	4	30	..... hrs. ..... min.

9. Birthplace: Marlboro Md

(Town, county, and state)

10. Usual occupation: At Home

11. Industry or business

FATHER

12. Name: Wesley Johnson

13. Birthplace: Del. Co., Md.

MOTHER

14. Maiden name: Elvira Starke

15. Birthplace: Chas Co. Md.

16. Informant: Elvira Johnson

Address: Ironsides Md.

17. Burial: (Burial, cremation, or removal. Which?) Date thereof: Nov. 13 45 (month) (day) (year)

Cemetery or crematory: Oak Grove

Location: near Pinkside Md.

18. Funeral director: Penny & Cooley

Address: Indian Springs Md

19. Nov. 13 1945 (Date rec'd by registrar) Brooke E Bowie Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 9 1945 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940, to 1945

and that I last saw h... alive on ..... 19.....

	DURATION
Immediate cause of death: Cerebral Epilepsy	
Due to: Epilepsy	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Geo. C. Bickell M.D.

M. D. or other

Address: Bryantown Md Date signed: Nov. 13 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23(a)

11006

CERTIFICATE OF DEATH

★ Reg. Dist. No. 104

1. PLACE OF DEATH:
County: Charles
City or town: Newburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Charles
City or town: Newburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Ella Lanham

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	widowed

6.(b) Name of husband or wife: J. Samuel Lanham
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Sept. 4 - 1859

8. AGE:

Years	Months	Days	If less than one day
86	1	24	..... hrs. ..... min.

9. Birthplace: Cristfield Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: George Dashiell
13. Birthplace: Cristfield
MOTHER 14. Maiden name: Ella Wilson
15. Birthplace: Cristfield
16. Informant: Mary E. Jones
Address: Newburg.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-24-45 (month) (day) (year)
Cemetery or crematory: Evening Rest
Location: Cristfield, Md.
18. Funeral director: [illegible]
Address: Kuldoss & Cristfield
19. 11/27/45 (Date rec'd by registrar) William J. Freer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11 - 27 - 1945, at 6 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1, 1945, to Nov. 27, 1945 and that I last saw h[illegible] alive on Nov. 27 - 1945

Immediate cause of death	DURATION
Apoplexy	2 days
Due to: Rheumatism	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: T. L. Hazelton, M. D. or other
Address: Mayfield Date signed 11-27-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 175

CERTIFICATE OF DEATH

Reg. Dist. No. 106

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Charles
City or town: Indian Head, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 Months
Hospital, institution, or street address where death occurred: Potomac River
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington (If outside city or town limits, write RURAL and give nearest town)
Street No. 1320 - 31st. St. N.W. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Lt. Comdr. David F. LEAVITT USNR

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): 8-28-97

8. AGE: Years	Months	Days	If less than one day
48	7	23	hrs. min.

9. Birthplace: St. Louis, Mo. (Town, county, and state)
10. Usual occupation: Artist
11. Industry or business
FATHER 12. Name: Franklin Leavitt
FATHER 13. Birthplace: St Louis, Mo.
MOTHER 14. Maiden name: Margaret Nash Leavitt
MOTHER 15. Birthplace: Louisville, Ky.
16. Informant: Navy Department Records, Address: Washington, D.C.
17. Removal (Burial, cremation, or removal. Which?) Date thereof 5 March 1946 (month) (day) (year)
Cemetery or crematory: Arlington National Cem.
Location: Washington, D.C.
18. Funeral director: George Wise
Address: 2900 M.St. N.W. Washington, D.C.
19. 3/5 (Date rec'd by registrar) 1946 Odey Preece Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12 November 1945, at 9. Mp. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on 5 March 1946

Immediate cause of death	DURATION
Asphyxiation	
Due to: Drowning	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of Nov. 12, 1945
Where did injury occur? Indian Head, Md. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Potomac River
Means of injury: Plane crash Injured at work? Yes

23. SIGNATURE: Frank G. Susan M.D. M. D. or other
Address: Indian Head, Md. Date signed:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (105)

CERTIFICATE OF DEATH

11067

Reg. Dist. No. 100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Charles

City or town: La Plata

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: La Plata

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME James Calvin Mason

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 7, 1945

8. AGE: Years	Months	Days	If less than one day
0	6		..... hrs. ..... min.

9. Birthplace: La Plata, Charles, Md. (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER 12. Name: Guy Mason

13. Birthplace: Spring Hill, Md.

MOTHER 14. Maiden name: Mary Smith

15. Birthplace: La Plata, Md.

16. Informant: Guy Mason

Address: La Plata, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-12-45 (month) (day) (year)

Cemetery or crematory: Newtowne Church

Location: Newtowne, Md.

18. Funeral director: Guy Mason

Address: La Plata, Md.

19. 11-12 (Date rec'd by registrar) 1945 Julia K. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 10, 1945 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ~~on~~ Nov. 12, 1945, to ——— 19——

and that I ~~last~~ saw h~~im~~ ~~alive~~ on Nov. 12, 1945

Immediate cause of death	DURATION
Probably, acute laryngitis	3-4 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Dep. Med. Examiner James E. MacKenzie, M.D. M. D. or other

Address: La Plata, Md. Date signed 11-12-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-2)

CERTIFICATE OF DEATH

11008

Reg. Diat. No. 104

1. PLACE OF DEATH:
County: Charles
City or town: Shiloh
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Charles
City or town: Shiloh
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: George H. Shade

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	B	Married

6.(b) Name of husband or wife: Nannie M. Shade
6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): Oct. 22 1869

8. AGE: Years	Months	Days	If less than one day
76	1	2	hrs. min.

9. Birthplace: Shiloh Md.
(Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business

FATHER
12. Name: Wesley Shade
13. Birthplace: Shiloh Md.

MOTHER
14. Maiden name: Eliza Folsom
15. Birthplace: Newburg Md.

16. Informant: Brooks G. Shade
Address: Newburg

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-25-45 (month) (day) (year)
Cemetery or crematory: Shiloh
Location: Near Waldorf Md.

18. Funeral director: Penny & Cofer
Address: Mason Springs

19. 11/24 1945 Wm. J. Lobe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11-21- 1945, at 11 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-21- 1945 to 11-21- 1945 and that I last saw h... alive on 11-21- 1945

Immediate cause of death	DURATION
Apoplexy	12 hours
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: T. L. Hyslop M. D. or other
Address: Waldorf Date signed 11-24-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11609/06

1. PLACE OF DEATH:
County: Charles
City or town: Indian Head
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Charles
City or town: Indian Head
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME John Henry Stepney

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	married

6.(b) Name of husband or wife: Emma Clark Stepney
6.(c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): September 5, 1900

8. AGE: Years	Months	Days	If less than one day
45	2	21	hrs. min.

9. Birthplace: West Va.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Last worked on State Road

FATHER
12. Name: John Stepney
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Eva Stewart
15. Birthplace: W. Va.

16. Informant: Emma Stepney
Address: Indian Head Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 29. 1945 (month) (day) (year)
Cemetery or crematory: St. Charles Catholic
Location: Glymont, Md
18. Funeral director: Hunt & Ryon
Address: Waldorf. Md.

18. 11/28 1945 Odey Price
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 26 19 45 at 5P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to Nov. 26 19 45
and that I last saw h... alive on Nov. 26 19 45

Immediate cause of death	DURATION
Coronary Thrombosis	1 day.
Due to: Hypertensive Heart Disease.	5 years.
Due to:	
Other conditions: Had had (probably) Rheumatic fever 4 yrs ago & was troubled since.	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank G. Susan M.D.
M. D. or other
Address: Indian Head Md. Date signed 11/27/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11610

107

CERTIFICATE OF DEATH

Reg. Dist. No. 101

1. PLACE OF DEATH

County Charles

City or town Marbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Charles

City or town Marbury

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Samuel K. Swailes

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	S

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 7 1944

8. AGE: Years 1 Months 5 Days 5 If less than one day ..... hrs. ..... min.

9. Birthplace Pomonkey Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Jas. E. Swailes.

FATHER 13. Birthplace Indian Head Md

MOTHER 14. Maiden name Zelda Mae Plummer

MOTHER 15. Birthplace Marbury Md

16. Informant Jas E. Swailes

Address Marbury, Md

17. Burial Date thereof Nov 17 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Pleasant Grove

Location Marbury, Md.

18. Funeral director Penny & Peters

Address Mason Springs Md

19. 11/15/45 Mary Swailes Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15 1946 at 6 40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 14 1945 to ..... 19..... and that I last saw h.... alive on Nov. 14 1946

Immediate cause of death	DURATION
Ac. Congestion Pulmonary	
Broncho Pneumonia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Geo. C. Bickell M.D.
M. D. or other

Address Marbury, Md. Date signed Nov. 16 46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

11011

2411 N. Charles St., Baltimore (195-d)

CERTIFICATE OF DEATH

Reg. Diat. No. 100

1. PLACE OF DEATH:

County: Charles

City or town: La Plata

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos.

Hospital, Institution, or street address where death occurred:

Nr. Spring Hill

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: La Plata

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Nr. Spring Hill

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Thomas Ray West, Jr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): June 17, 1945

8. AGE:

Years	Months	Days	If less than one day
0	4	24	... hrs. ... min.

9. Birthplace: Augusta Co. Va.

(Town, county, and state)

10. Usual occupation: Enfant

11. Industry or business:

FATHER — 12. Name: Thomas Ray West

13. Birthplace: Rockville, Md.

MOTHER — 14. Maiden name: Margaret Radcliffe

15. Birthplace: Wash., D.C.

16. Informant: A. L. Radcliff (grandfather)

Address: La Plata, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-13-45 (month) (day) (year)

Cemetery or crematory: St Ignatius

Location: Bel Alton, Md.

18. Funeral director: Hewitt & Ryon

Address: Waldorf Md

19. 11-12 1945 (Date rec'd by registrar) Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 10, 1945 about 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ON Nov. 10, 1945, to 1945 and that I last saw him alive on Nov. 10, 1945

Immediate cause of death	DURATION
Accidental asphyxia	Minutes
Due to: aspiration of vomitus	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 11-10-45

Where did injury occur? La Plata, Charles, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: aspirated vomitus Injured at work? No

Dep. Med. Examiner

23. SIGNATURE: James L. MacKenzie, M.D. M. D. or other

Address: La Plata, Md. Date signed 11-10-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING